FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032839

Facility Name: GLENWOOD HEALTHCARE & REHAB

Address: 19330 S. COTTAGE GROVE AVE. (Number) GLENWOOD (City) 60425 (Zip Code)

County: COOK

Telephone Number: (847) 674 - 4700 **Fax #** (847) 674 - 4733

IDPA ID Number: 36-3532094

Date of Initial License for Current Owners: 09/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,672	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,672	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	184	TOTALS	184	67,344	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,618	1,618	8
9	SNF/PED					9
10	ICF	46,812	4,775	2,016	53,603	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,812	4,775	3,634	55,221	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 82.00%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 1618

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number GLENWOOD HEALTHCARE & REH # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	190,408	20,105	11,998	222,511		222,511	0	222,511			1
2	Food Purchase		207,496		207,496		207,496	(14,413)	193,083			2
3	Housekeeping	196,351	30,638	0	226,989		226,989	587	227,576			3
4	Laundry	113,434	33,469	2,188	149,091		149,091	0	149,091			4
5	Heat and Other Utilities			103,532	103,532		103,532	462	103,994			5
6	Maintenance	46,080	25,172	15,660	86,912		86,912	3,926	90,838			6
7	Other (specify):*			7,021	7,021		7,021	0	7,021			7
8	**TOTAL General Services**	546,273	316,880	140,399	1,003,552		1,003,552	(9,438)	994,114			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000	0	6,000			9
10	Nursing and Medical Records	1,386,432	66,519	404,724	1,857,675		1,857,675	9,431	1,867,106			10
10a	Therapy	55,278	1,969	2,661	59,908		59,908	0	59,908			10a
11	Activities	147,369	2,857	5,228	155,454		155,454	0	155,454			11
12	Social Services	56,793		2,838	59,631		59,631	0	59,631			12
13	Nurse Aide Training			13,051	13,051		13,051	0	13,051			13
14	Program Transportation			200	200		200	0	200			14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,645,872	71,345	434,702	2,151,919		2,151,919	9,431	2,161,350			16
	C. General Administration											
17	Administrative	97,956		41,400	139,356		139,356	9,920	149,276			17
18	Directors Fees			0				0				18
19	Professional Services			185,207	185,207		185,207	16,612	201,819			19
20	Dues, Fees, Subscriptions & Promotions			48,877	48,877		48,877	(21,691)	27,186			20
21	Clerical & General Office Expense	78,890	27,016	144,493	250,399		250,399	(42,647)	207,752			21
22	Employee Benefits & Payroll Taxes			297,902	297,902		297,902	0	297,902			22
23	Inservice Training & Education			857	857		857	0	857			23
24	Travel and Seminar			937	937		937	9,217	10,154			24
25	Other Admin. Staff Transportation			7,054	7,054		7,054	3,415	10,469			25
26	Insurance-Prop.Liab.Malpractice			63,719	63,719		63,719	3,033	66,752			26
27	Other (specify):*			0				43,821	43,821			27
28	**TOTAL General Administration**	176,846	27,016	790,446	994,308		994,308	21,680	1,015,988			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,368,991	415,241	1,365,547	4,149,779		4,149,779	21,673	4,171,452			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number GLENWOOD HEALTHCARE & REH # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			49,861	49,861		49,861	165,833	215,694			30
31	Amortization of Pre-Op. & Org.							24,546	24,546			31
32	Interest			50,375	50,375		50,375	550,331	600,706			32
33	Real Estate Taxes			435,425	435,425		435,425	0	435,425			33
34	Rent-Facility & Grounds			755,550	755,550		755,550	(748,460)	7,090			34
35	Rent-Equipment & Vehicles			11,187	11,187		11,187	5,105	16,292			35
36	Other (specify):*							0				36
37	TOTAL Ownership			1,302,398	1,302,398		1,302,398	(2,645)	1,299,753			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		48,333	68,932	117,265		117,265	0	117,265			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			101,016	101,016		101,016	0	101,016			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		48,333	169,948	218,281		218,281		218,281			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,368,991	463,574	2,837,893	5,670,458	0	5,670,458	19,028	5,689,486			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(46,323)	30		9
10	Interest and Other Investment Income	(23)	32		10
11	Discounts, Allowances, Rebates & Refunds	(13,837)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(576)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(19)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(24,356)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(2,039)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	3,771	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (83,552)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	102,580	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 102,580		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 19,028		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name GLENWOOD HEALTHCARE & REHAB

IDPH 0032029

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary	Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43
The information listed in B13 thru G43 is from Page 5.																																											
1	**Day Care**	0	0	**Line 1**	0																																						
2	**Other Cars for Outpatients**	0	0	**Line 2**	(14,472)																																						
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0																																						
4	**Non-Patient Meals**	0	2	**Line 4**	0																																						
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0																																						
6	**Rented Facility Space**	0	34	**Line 6**	5,771																																						
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0																																						
8	**Laundry for Non-Patients**	0	4	**Line 8**	(10,847)																																						
9	**Non-Straightline Depreciation**	(46,323)	30	**Line 9**	0																																						
10	**Interest and Other Investment Income**	(23)	32	**Line 10**	0																																						
11	**Discounts, Allowances, Rebates & Refunds**	(11,837)	2	**Line 10a**	0																																						
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0																																						
13	**Sales Tax**	(576)	2	**Line 12**	0																																						
14	**Non-Care Related Interest**	0	32	**Line 13**	0																																						
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0																																						
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0																																						
17	**Non-Care Related Fees**	(150)	20	**Line 16**	0																																						
18	**Fines and Penalties**	(19)	21	**Line 17**	0																																						
19	**Entertainment**	0	20	**Line 18**	0																																						
20	**Contributions**	0	20	**Line 19**	0																																						
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(26,340)																																						
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	737																																						
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0																																						
24	**Bad Debt**	0	27	**Line 23**	0																																						
25	**Fund Raising, Advertising and Promotional**	(24,356)	20	**Line 24**	0																																						
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0																																						
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0																																						
28	**Yellow Page Advertising**	(2,039)	20	**Line 27**	0																																						
29	**Non-Paid Workers**	0	0	**Line 28**	(26,564)																																						
30	**Donated Goods**	0	0	**Line 29**	(37,208)																																						
31	**Amortization Expense**	0	0	**Line 30**	(46,323)																																						
32	DEFERRED MAINTENANCE	5,771	6	**Line 31**	0																																						
33				**Line 32**	(83)																																						
34				**Line 33**	0																																						
35				**Line 34**	0																																						
36				**Line 35**	0																																						
37				**Line 36**	0																																						
38				**Line 37**	(46,240)																																						
39				**Line 38**	0																																						
40				**Line 39**	0																																						
41				**Line 40**	0																																						
42				**Line 41**	0																																						
43				**Line 42**	0																																						
44				**Line 43**	0																																						
45				**Line 44**	0																																						
46				**Line 45**	(83,729)																																						

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,413)	0	0	0	0	0	0	0	0	0	0	(14,413)	2
3	Housekeeping	0	0	587	0	0	0	0	0	0	0	0	587	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	462	0	0	0	0	0	0	0	0	462	5
6	Maintenance	3,771	0	155	0	0	0	0	0	0	0	0	3,926	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,642)	0	1,204	0	0	0	0	0	0	0	0	(9,438)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	9,431	0	0	0	0	0	0	0	0	9,431	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	9,431	0	0	0	0	0	0	0	0	9,431	16
	C. General Administration													
17	Administrative	0	(41,400)	51,320	0	0	0	0	0	0	0	0	9,920	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,350	15,262	0	0	0	0	0	0	0	0	16,612	19
20	Fees, Subscriptions & Promotions	(26,545)	0	4,854	0	0	0	0	0	0	0	0	(21,691)	20
21	Clerical & General Office Expenses	(19)	(124,613)	81,985	0	0	0	0	0	0	0	0	(42,647)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	9,217	0	0	0	0	0	0	0	0	9,217	24
25	Other Admin. Staff Transportation	0	0	3,415	0	0	0	0	0	0	0	0	3,415	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,033	0	0	0	0	0	0	0	0	3,033	26
27	Other (specify):*	0	0	43,821	0	0	0	0	0	0	0	0	43,821	27
28	**TOTAL General Administration**	(26,564)	(164,663)	212,907	0	0	0	0	0	0	0	0	21,680	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,206)	(164,663)	223,542	0	0	0	0	0	0	0	0	21,673	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(46,323)	207,945	4,211	0	0	0	0	0	0	0	0	165,833	30
31	Amortization of Pre-Op. & Org.	0	24,546	0	0	0	0	0	0	0	0	0	24,546	31
32	Interest	(23)	549,655	699	0	0	0	0	0	0	0	0	550,331	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(755,550)	7,090	0	0	0	0	0	0	0	0	(748,460)	34
35	Rent-Equipment & Vehicles	0	0	5,105	0	0	0	0	0	0	0	0	5,105	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(46,346)	26,596	17,105	0	0	0	0	0	0	0	0	(2,645)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(83,552)	(138,067)	240,647	0	0	0	0	0	0	0	0	19,028	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD HEALTHCARE & REHAI # 0023829 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRADLEY ALTER	22.83	SCHEDULE ATTACHED		CERTIFIED HEAL	SKOKIE	BOOKKEEPING/
HOWARD GELLER	38.04			MANAGEMENT		MANAGEMENT
CYNTHIA CHOW	39.13			CHM THREAPY	SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1 V	17	MANAGEMENT FEES	$ 41,400	CERTIFIED HEALTH MANAGEMEN	6	6	(41,400)	1	-41400
2 V	21	BOOKKEEPING	124,640	CERTIFIED HEALTH MANAGEMEN			(124,640)	2	-124640
3 V								3	
4 V								4	
5 V								5	
6 V	24	RENT	755,550	GLENWOOD TERRACE LLC			(755,550)	6	-755550
7 V								7	
8 V	19	PROFESSIONAL FEES				1,350	1,350	8	1350
9 V	20	DEPRECIATION				207,945	207,945	9	207945
10 V	23	AMORTIZATION				24,546	24,546	10	24546
11 V	22	INTEREST				549,655	549,658	11	549655
12 V	21	OFFICE EXPENSE				27	27	12	27
13 V								13	
14 Total			$ 921,590			$ 783,523	$ * (138,067)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	3	HOUSEKEEPING	$			$ 587	$ 587	15	587
16	V	5	ELECTRICITY & GAS				462	462	16	462
17	V	6	MAINTENANCE				155	155	17	155
18	V	10	NURSING & MEDICAL RECORDS				9,431	9,431	18	9431
19	V	17	ADMIN SALARIES				51,320	51,320	19	51320
20	V	19	PROFESSIONAL FEES				15,262	15,262	20	15262
21	V	20	FEES, SUBSCRIPTION				4,854	4,854	21	4854
22	V	21	OFFICE EXPENSE				81,985	81,985	22	81985
23	V	27	EMPLOYEE BENEFITS				43,821	43,821	23	43821
24	V	24	TRAVEL & SEMINAR				9,217	9,217	24	9217
25	V	25	TRANSPORTATION				3,415	3,415	25	3415
26	V	26	INSURANCE				3,033	3,033	26	3033
27	V	30	DEPRECIATION				4,211	4,211	27	4211
28	V	32	INTEREST				699	699	28	699
29	V	34	OFFICE RENT				7,090	7,090	29	7090
30	V	35	EQUIPMENT RENT				5,105	5,105	30	5105
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 240,647	$ * 240,647	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number GLENWOOD HEALTHCARE & REI # 0032839 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 32,757	17-7	1
2	HOWARD GELLER		ADMINISTRATIVE		SCHEDULE ATTACHED			MGMT FEE	8,775	19-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 41,532		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT C... Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: CERTIFIED HEALTH MANAGEMEN
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	282,193	8	$ 3,000	$	55,221	$ 587	1
2	5	ELECTRICITY & GAS	" "	282,193	8	2,363		55,221	462	2
3	6	MAINTENANCE	" "	282,193	8	794		55,221	155	3
4	10	NURSING & MEDICAL REC	" "	282,193	8	48,193	48,193	55,221	9,431	4
5	17	ADMIN SALARIES	" "	282,193	8	262,258	262,258	55,221	51,320	5
6	19	PROFESSIONAL FEES	" "	282,193	8	103,352		55,221	15,262	6
7	20	FEES, SUBSCRIPTION	" "	282,193	8	24,805		55,221	4,854	7
8	21	OFFICE EXPENSE	" "	282,193	8	418,964	287,637	55,221	81,985	8
9	27	EMPLOYEE BENEFITS	" "	282,193	8	223,938		55,221	43,821	9
10	24	TRAVEL & SEMINAR	" "	282,193	8	47,103		55,221	9,217	10
11	25	TRANSPORTATION	" "	282,193	8	17,449		55,221	3,415	11
12	26	INSURANCE	" "	282,193	8	15,497		55,221	3,033	12
13	30	DEPRECIATION	" "	282,193	8	21,518		55,221	4,211	13
14	32	INTEREST	" "	282,193	8	3,570		55,221	699	14
15	34	OFFICE RENT	" "	282,193	8	36,234		55,221	7,090	15
16	35	EQUIPMENT RENT	" "	282,193	8	26,088		55,221	5,105	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,255,126	$ 598,088		$ 240,647	25

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Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Print Page 8

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Facility Name & ID Number GLENWOOD HEALTHCARE & REH # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	BARRY KIRSCHENBAUM	X		MORTGAGE	$48,244.00	01/01/99	$ 5,796,000	$ 5,664,704	01/01/24	8.9	$ 549,655	1
2												2
3												3
4												4
5												5
	Working Capital											
6	OLD KENT BANK		X	WORKING CAPITAL	DEMAND			624,038		PRIME +	50,375	6
7												7
8	RELATED PARTY										699	8
9	TOTAL Facility Related				$48,244.00		$ 5,796,000	$ 6,288,742			$ 600,729	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,796,000	$ 6,288,742			$ 600,729	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	358,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	392,834	2
3. Under or (over) accrual (line 2 minus line 1).	$	34,734	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	400,691	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	435,425	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	329,415	8
	1996	332,223	9
	1997	345,013	10
	1998	351,119	11
	1999	392,834	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Previe

Facility Name & ID Numb GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,010 B. General Construction Type: Exterior BRICK Frame 1 Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1999	$ 322,000	1
2					2
3	TOTALS			$ 322,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	184		1999		$ 5,474,000	$ 140,359	39	$ 140,359	$	$ 280,718	4
5											5
6											6
7											7
8						466		466			8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	LEASEHOLD IMPROVEMENTS			1988	20,662	656	30	688	32	8,601	9
10	LEASEHOLD IMPROVEMENTS			1989	4,071	129	30	136	7	1,564	10
11	LEASEHOLD IMPROVEMENTS			1990	28,171	894	30	939	45	9,860	11
12	LEASEHOLD IMPROVEMENTS			1991	31,712	1,007	30	1,057	50	10,042	12
13	LEASEHOLD IMPROVEMENTS			1992	10,071	320	30	336	16	2,856	13
14	LEASEHOLD IMPROVEMENTS			1993	4,810	123	30	160	37	1,263	14
15	LEASEHOLD IMPROVEMENTS			1994	17,744	455	30	592	137	3,847	15
16	LIGHT FIXTURES, ROOM SIGNS, HAND RAILS			1995	6,343	162	39	162		1,113	16
17	HEATING & AIR CONDITIONER			1995	12,515	321	39	321		2,180	17
18	NURSING STATION			1995	10,384	266	39	266		1,718	18
19	SPRINKLER & LAUNDRY VENTILATION REPAIR			1995	2,360	61	39	61		380	19
20	LAMPS, VIDEO CAMERA, PANIC DEVICE, WATER COOLI			1996	3,650	94	39	94		531	20
21	EXIT & OUTDOOR SIGN			1996	4,237	108	39	108		592	21
22	WINDOWS, DOORS, CEILING TILES & CARPET			1996	25,090	643	39	643		3,346	22
23	HVAC WIRING REPAIR			1996	1,540	40	39	40		205	23
24	TIME CLOCKS, HEAT & COOL UNITS			1997	7,022	180	39	180		638	24
25	NURSE STATION			1997	5,615	144	39	144		510	25
26	FLOOR & CEILING TILES, COUNTER & CABINETS			1997	21,659	555	39	555		2,040	26
27	DOORS, LIGHTS & SIGNS			1997	14,825	380	39	380		1,418	27
28	BURNERS & ELECTRIC FOR WASHER			1997	1,964	50	39	50		177	28
29	SIGNS, PATIO SURFACE			1998	6,994	466	15	466		1,165	29
30	WINDOWS & INSTALLATION			1998	18,944	486	39	486		1,438	30
31	KITCHEN REMODEL			1998	50,500	1,295	39	1,295		3,833	31
32	ELECTRIC WORK			1998	7,545	193	39	193		491	32
33	CARPET, WALLPAPER, HANDRAIL, BUMPER GUARD			1998	79,382	2,036	39	2,036		4,601	33
34	GENERATOR			1999	56,533	1,450	39	1,450		2,841	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 153,339		$ 153,663	$ 324	$ 347,968	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	HEAT AND AIR CONDITIONER			1999	14,673	376	39	376		580	9
10	VINYL FLOORING AND TILES			1999	5,505	141	39	141		206	10
11	ROOF AND TUCKPOINT			1999	59,360	1,522	39	1,522		2,094	11
12	AIR CONDITIONER/COMPRESSOR			2000	9,868	1,410	20	1,410		1,410	12
13	ROOF REPAIR			2000	3,750	108	27.5	108		108	13
14	VINYL TILE/COVE BASE			2000	19,277	488	27.5	488		488	14
15	ALARM WORK			2000	3,848	26	27.5	26		26	15
16											16
17											17
18											18
19											19
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21											21
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 4,071		$ 4,071	$	$ 4,912	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 275,938	$ 29,394	$ 26,162	$ (3,232)	10 YRS	$ 146,940	37
38	Current Year Purchases	24,305	3,883	1,215	(2,668)	10 YRS	1,215	38
39	Fully Depreciated Assets	4,850					4,850	39
40	RELATED PARTY	305,832	71,330	30,583	(40,747)		61,166	40
41	TOTALS	$ 610,925	$ 104,607	$ 57,960	$ (46,647)		$ 214,171	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 262,017	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 215,694	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (46,323)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 567,051	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 11,187 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ___

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 15,980	$		$ 15,980	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				333			333	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				52,442			52,442	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					29,306		29,306	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):	39 - 2 & 3					177	19,027		19,204	13
14	TOTAL				$		$ 68,932	$ 48,333		$ 117,265	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Previe

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 82,000)	856,558		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,935		6
7	Other Prepaid Expenses	1,957		7
8	Accounts Receivable (owners or related parties)	63,943		8
9	Other(specify): RE ESCROW	201,976		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,231,369	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	328,486		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	570,624		15
16	Equipment, at Historical Cost	394,237		16
17	Accumulated Depreciation (book methods)	(383,597)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 909,750	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,141,119	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 386,399	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,905		28
29	Short-Term Notes Payable	191,810		29
30	Accrued Salaries Payable	123,592		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,836		31
32	Accrued Real Estate Taxes(Sch.IX-B)	400,691		32
33	Accrued Interest Payable	2,635		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	58,435		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,179,303	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	144,320		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	LINE OF CREDIT	624,038		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 768,358	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,947,661	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 193,458	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,141,119	$	48

***(See instructions.)**

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Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 395,799	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 395,799	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	18,859	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(221,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (202,341)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 193,458	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,658,038	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,658,038	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	23,651	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 23,651	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 23	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**	13,837	28
28a	**VENDING COMMISSION**	1,268	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,105	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 5,696,817	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,003,552	31
32	Health Care	2,151,919	32
33	General Administration	994,308	33
	B. Capital Expense		
34	Ownership	1,302,398	34
	C. Ancillary Expense		
35	Special Cost Centers	117,265	35
36	Provider Participation Fee	101,016	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,670,458	40
41	**Income before Income Taxes (line 30 minus line 40)****	26,359	41
42	**Income Taxes**	7,500	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 18,859	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,960	3,080	$ 61,181	$ 19.86	1
2	Assistant Director of Nursing	2,228	2,308	35,693	15.46	2
3	Registered Nurses	17,182	17,774	260,089	14.63	3
4	Licensed Practical Nurses	25,183	25,458	279,364	10.97	4
5	Nurse Aides & Orderlies	74,745	76,405	652,645	8.54	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,871	5,391	55,278	10.25	8
9	Activity Director	3,920	4,160	43,794	10.53	9
10	Activity Assistants	16,413	17,078	103,575	6.06	10
11	Social Service Workers	5,931	6,053	56,793	9.38	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	34,456	16.57	13
14	Head Cook	4,591	5,027	42,688	8.49	14
15	Cook Helpers/Assistants	15,881	16,833	113,264	6.73	15
16	Dishwashers					16
17	Maintenance Workers	3,917	4,060	46,080	11.35	17
18	Housekeepers	23,768	24,873	196,351	7.89	18
19	Laundry	15,168	16,044	113,434	7.07	19
20	Administrator	2,468	2,578	62,100	24.09	20
21	Assistant Administrator	1,980	2,080	35,856	17.24	21
22	Other Administrative					22
23	Office Manager	5,233	7,380	65,475	8.87	23
24	Clerical	1,980	2,080	13,415	6.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,821	2,768	17,261	6.24	31
32	Other Health MEDICARE NU	3,202	3,242	37,721	11.64	32
33	Other(specify CARE PLAN CO	1,980	2,080	42,478	20.42	33
34	TOTAL (lines 1 - 33)	237,382	248,832	$ 2,368,991 *	$ 9.52	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 10,761	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant		23,842	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		1,215	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		1,378	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		5,228	11-3	44
45	Social Service Consultant		2,838	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		420	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 51,682		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	48	$ 1,191	10-3	50
51	Licensed Practical Nurses	2,637	55,387	10-3	51
52	Nurse Aides	15,364	276,546	10-3	52
53	TOTAL (lines 50 - 52)	18,049	$ 333,124		53

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